Clinical Quality Workgroup
Draft Transcript
June 6, 2011

Presentation

Judy Sparrow – Office of the National Coordinator
Good afternoon, everybody, and welcome to the Standards Committee's Clinical Quality Workgroup. This is a federal advisory call, so there will be opportunity at the end of the call for the public to make comment. Just a reminder: Workgroup members, please identify yourselves when speaking.

I'll do a quick roll call. Jim Walker?

Jim Walker – Geisinger Medical Education
Here.

Judy Sparrow – Office of the National Coordinator
Karen Kmetik?

Karen Kmetik – American Medical Association
Here.

Judy Sparrow – Office of the National Coordinator
David Baker? Chris Chute? Bob Dolin? Floyd Eisenberg?

Floyd Eisenberg – National Quality Forum
Present.

Judy Sparrow – Office of the National Coordinator
David Lansky? Eva Powell? Phil Renner's dialing in late. Danny Rosenthal? Joachim Roski? Rosemary Kennedy?

Rosemary Kennedy – National Quality Forum
Present.

Judy Sparrow – Office of the National Coordinator
Marjorie Rallins?

Marjorie Rallins – American Medical Association
Present.

Judy Sparrow – Office of the National Coordinator
OK. John Derr could not make it. Tom Tsang?

Tom Tsang – Office of the National Coordinator
Yes, here.

Judy Sparrow – Office of the National Coordinator
Patrice Holtz?

Patrice Holtz – Centers for Medicare & Medicaid Services
Here.

Judy Sparrow – Office of the National Coordinator
Ken Gebhart?

Ken Gebhart – National Institute of Standards and Technology
Present.

Judy Sparrow – Office of the National Coordinator
And for the record, Anne Castro and Gene Nelson could not make the call. Did I leave anyone off? [Pause] OK, I'll turn it over to Dr. Walker and Karen Kmetik.

Jim Walker – Geisinger Medical Education
Thank you, Judy. Just a brief welcome to everyone and an invitation to roll up your sleeves: We're going to hear about code set selection and a work plan to start accomplishing that. So I won't make any more comments but hand it over to Karen.

Karen Kmetik – American Medical Association
Well, thanks, Jim, and I think, if I understand correctly, we are going to today talk about code set selection, which is something we've talked about previously, and I think we've got some structure now by which to move forward on this type of work. Has Tom Tsang joined?

Tom Tsang – Office of the National Coordinator
Yes, I'm here, Karen.

Karen Kmetik – American Medical Association
Tom, do you want to just give a little background on that?

Tom Tsang – Office of the National Coordinator
Yeah. So we've been struggling with this for a while, and I think many know some of the challenges and hurdles and the barriers in terms of implementing a lot of the clinical quality measures from stage 1. I think this is a very newly evolving field, as many of you know. So as we're going from claims-based and administrative-based clinical quality measures and go into implementing—oh, can someone mute? There's a lot of background noise. So I'm saying, as we're moving and shifting over to the e-specified world, we've heard from both vendors and providers and hospitals about some of the ambiguities of some of the e-measure logic. And some of it may have to do with some of the variation in terms of code sets and perhaps having too many optionalities in place.

So we've been working with NQF on this evolving quality data model and trying to standardize the vocabularies and the code sets and value sets for specifically the clinical data elements and clinical processes. I think Floyd and his team at NQF have done a wonderful job in terms of aligning within the S&I Framework and thinking about a long-term strategy of developing de novo measures using the same standardized dictionary with the standardized data model. And some of the work that we've been doing as well with the Clinical Quality Workgroup members over the last couple meetings is really teeing up the code set selection process. So I think, moving forward—and we have a very aggressive

timeline; I mean, from this Workgroup, hopefully we can make some recommendations and give some guidance to NQF about specifically the 22, 23 data elements that we need to give some advice on in terms of some of the vocabulary sets and the code sets in the context of the S&I Framework as well. ONC's also been working on a vocabulary harmonization process with the SDOs, and we'd like to tie this work in with that work as well.

So I'm going to hand the baton to Floyd, and perhaps he and Anand could give a very brief overview of what's being done and what we need to get done over the next few meetings. Floyd?

Floyd Eisenberg – National Quality Forum
Sure, I can take it, Tom. Thank you. What I'll do is, you had accessed me to give just a brief recap of where we were to start with. And as many of you remember, the Equality Data Model started with what was called the Quality Dataset, which—its origins were from the 2006 Quality Use Case that was sent out for how should this be implemented. And it was determined that we need a standard model of how to describe information and to use it in a consistent way to be able to handle quality, and it really needed to address data that was captured during usual clinical care or usual health data entry, I should say, related to any of these concepts. What we did learn in the retooling process and in identifying the work last year around the Quality Data Model is how to enhance it.

But we learned a number of issues that really need to be addressed, and one of the primary ones was around code sets or what vocabulary code set should be used for every kind of information that you're looking for so that we're consistent with the same kind of code set that would be used to say that thing (and we'll get to the list of different ideas), whether you're directly caring for the patient or pulling the data for public health reporting, quality, or other purpose. But also, because the capability of even looking through any of these code sets to determine the right terms or the right branch of that code set to use, the expertise is not present everywhere that we need it to be to enhance this. So one is to identify which code set or vocabulary, and the other is to establish in some way a registry of these things so that they could be reused. And I'll get back to that in a minute.

Some of the other things were identified—is, in order to identify patient-reported outcomes, some of the data that would be required and is often embedded within templates or validated instruments—some of them are the same data you'd use for routine care, but some are specific. And in cases like that, the ability for an EHR to use a validated template and have those registered in the appropriate code set, whether LOINC or SNOMED, for instance, would be helpful. The other we learned is, if we're trying to think of conditions and problems, it implies that somehow we need to make sure there are standards to indicate a problem as active or inactive or resolved and "What is the date of onset?" and that all of that is implemented in clinical applications. We also have to do something similar around allergies ("How do I define an allergy?") and around a plan of care ("How do we define it?").

So some of those are general issues; today we're going to address code sets primarily. So is Anon on, or would you like me to go into the Vocabulary Task Force [indiscernible]? [Pause] OK, I'll take it, then.

The Vocabulary Task Force is another workgroup under the Clinical Operations Workgroup for the Standards Committee. And they originally reviewed two different concepts and came up with some definitions. One is a convenient set or a subset of any known code set, so you could take that as the 80% of commonly known problems to use in a problem list that can be incorporated in an EHR for implementation or the 80%–90% of common laboratories that are used so that, when it's first put into

effect and implemented, that EHR can have a robust set of terms for use that can be reused and recognized, knowing that there are terms that will come into the EHR that are not in that set, and needs a way to deal with those. But that's what they call the convenience or subset.

There's also what they determined the name for as value sets, and this is actually an HL7 standard. The value sets, in their terminology for task force, are the specific set of either enumerated values or a specific branch of SNOMED, for instance, that would say what you're looking for in any one case. So if I just wanted to say "diabetes," what branch of SNOMED or what enumerated list would I use so that I can indicate diabetes in my clinical measure? So those are the more specific value sets, which often are derived from a convenience or subset, but not always.

So that's what they've been working on. And they're identifying a standard subset or convenience set for labs in LOINC, and that's been presented in work done by Regenstrief around common labs or the member organizations. They're looking at the same with problems, and they'll be looking at some other issues as well, but that's where that game is at this point. Is there more background you would like, Tom, on that activity?

Tom Tsang – Office of the National Coordinator
No, I think that's fine. Thank you.

Floyd Eisenberg – National Quality Forum
So I think what you're suggesting, then, is to move into—and actually, I can deal with some of these questions. As you look at some of the concepts we're going to look at next, you need to be thinking about "Are these concepts present, or should they be, in the current standards used for interoperability, like C32 and CCR? How do they support longitudinal measurement?" And I think we've tried to explain some of that on prior calls. "And how can we incorporate self-reported data?"

So I think if we move to the spreadsheet, I can take you through and show you how we hold these together. In the Quality Data Model, we actually have—did anyone not receive the spreadsheet in the email?

Jim Walker – Geisinger Medical Education
This is the one labeled "Code Set Vocabulary Proposal"?

Floyd Eisenberg – National Quality Forum
That's correct. OK, and now you're seeing it on screen as well.

So what you'll see here is, we've started with a—we called it "concept," and from feedback I'm getting, I think we should be using the term "category." But basically we're dealing with a certain type of information, so the first one is "allergy." There's a definition coming from the QDM version 3 definition to explain what we're looking for. And what is in the column to the right of the definition is what might make sense from discussions that have occurred elsewhere or at the Vocabulary Task Force.

So what it's suggesting is to determine: Is it a type I hypersensitivity reaction you're looking for, if you want to be that specific, as opposed to just say "allergy" or say what kind of allergy or to say a severity, meaning moderate, severe, or mild? Those could come from SNOMED. To indicate what you're allergic it, it's been suggested that medications should be coming from RxNorm, because that's the central

terminology to which other terminologies map, and that could be discussed. There is the NDFRT, National Drug File Reference Terminology, and there may be others. What has been suggested is for components such as "I'm allergic to yellow dye #2," which addresses a number of oral meds—is that UNI be used. This also came from the Vocabulary Task Force. And for other concepts like substance, what you're allergic to could come from SNOMED or other vocabularies or other code sets. But unless we know what you'd use, then we can't necessarily describe quality measures consistently. So I'm not going to go through each one of these; I can as you'd like to, but it might be helpful to have discussion about this. And if you look through the spreadsheet, again—so "allergy" for the kind of allergy, SNOMED—but we're open for recommendation—RxNorm for meds, UNI for components, and then "see others."

"Characteristics": This particular category of the QDM is for any characteristic without the individual. So depending on what type of information (for instance, race or ethnicity), what is the set that should be used? CDC has a very large and complete set, some of which may be excessive for a small EHR and some may not. So that's one of the questions.

Unidentified Woman
Floyd?

Floyd Eisenberg – National Quality Forum
Yes.

Unidentified Woman
Oh, is it OK to interrupt, or I'll let you—

Floyd Eisenberg – National Quality Forum
I'll ask the chairs.

Unidentified Woman
Oh, OK.

Floyd Eisenberg – National Quality Forum
Do you want me to take questions as we go here, Jim and Karen?

Jim Walker – Geisinger Medical Education
Yeah, I think that's reasonable, particularly if they're clarifitory. This is Jim.

Karen Kmetik – American Medical Association
Yes.

Unidentified Woman
OK. Are you OK, Floyd, with getting a question, or do you want to complete the characteristics first?

Floyd Eisenberg – National Quality Forum
Oh, this is actually fine.

Unidentified Woman

OK. Just a basic validation: For some of these, multiple code sets may be needed, depending on what's being captured. And based on your work with looking at code sets and the underlying data models, do you see any potential conflicts in terms of the data model and how that may be a factor or play a role, or do you think it's at the level of granularity that it won't play a role as people are building the system? So I'm thinking of potential conflicts, and maybe I'm reading into it too much.

Floyd Eisenberg – National Quality Forum
It's a good question. I may have to ask you a question to clarify, but let me see if I caught this. For instance, if I say the CDC set up terms for ethnicity, if you want to develop a value set from that, a subgroup of that, to say, "These are the things I use in my measure," or maybe give a higher level, so you could say "all native Americans," and you don't have to deal with each tribe, and "all" something else, that would work in the model as it is. Where there may be issues—and I believe this comes up more in functional status, where we might have some terms in, say, the International Classification of Function (ICF) or in nursing terminologies, and how do I compare one to another? What we have suggested here—and again, this is only for consideration by this group—was a conclusion that was developed during HITSP considerations of nursing vocabulary, and also the Integrating Healthcare Enterprise (IHE) came to a similar conclusion, that SNOMED would be the terminology to be used—not for ICF, at least, but for the nursing ones—because it contains the majority of the nursing terminologies that were being considered. But yes, there can be conflicts.

Unidentified Woman
Yeah, I was thinking of that example that you just mentioned. Let's say "functional status," the ability of someone to do self-care management. And ICF may have a greater level of granularity in terms of precoordinated concepts, so you could really specify, maybe, with one term a person's ability to carry out self-care management—and may need multiple ones from SNOMED, or it may be vice versa. But that's where, potentially, I guess, if it's not real clear, there could be conflict. I don't mean conflict from a really negative perspective, but there is approaches to it.

Floyd Eisenberg – National Quality Forum
Yeah, and I don't disagree with that. I think that's part of what we're looking for: How do we resolve things like that when we're coming to vocabularies?

Unidentified Woman
OK, or make it be flexible enough to give recommendations, because people can't necessarily overnight rip out potential code sets. OK, thanks.

Floyd Eisenberg – National Quality Forum
Where we have our challenge—and I know, in some of our testimony, that this team, along with the Policy Committee Quality Workgroup, heard—is, having one rather than many is easier for a local implementer than for a vendor because of concerns of having to deal with more than one. The other challenge that I believe I heard loud and clear at the testimony was, if you're giving one, that there has to be a clear, easy to use, easy to find roadmap from one to another and tools so that whatever is there locally can be easily, without a lot of work, mapped to the terms needed in the measures. It is hard also for quality measures developers, who may know some subset of all the code sets out there, to have to deal with many if they're not familiar with all of them.

Tom Tsang – Office of the National Coordinator

Floyd, this is Tom. I have a question also. So looking at the 23 data elements that you're asking advice one, it seems like almost 90% of them are related to the issue of the problem list, whether it's SNOMED CT versus ICD-9/ICD-10. So would you characterize that the issue's really having the dual optionality for defining the diagnosis and so forth? And where you have instances where it's only one code set for that feature, like RxNorm for meds, that's not so much of an issue for you?

Floyd Eisenberg – National Quality Forum
Well, can I characterize it a little differently?

Tom Tsang – Office of the National Coordinator
Mm-hm.

Floyd Eisenberg – National Quality Forum
Actually, "condition/diagnosis/problem" is stated that way because folks couldn't agree on "Is it a condition, a diagnosis, or a problem?" So we were talking about the same thing, but instead of continuing discussion of what name to give it, we put it, "That's what it is," and defined it. So in that particular instance, we did—I mean, we're not trying to make the decision here at NQF, but from most of what we've heard, SNOMED CT seems to be the clinically appropriate terminology or code set, but most people are currently using ICD-9, and we know everyone has to move to '10 for 2013. So there's a question mark: "Could you have more than one?" Yes. I can tell you that the cost to developing them and to implementing them will be higher to do multiple, because one doesn't map directly to the other. Basically, if you have a concept, you look in SNOMED; you create a value set; then you look in ICD-10 and start from scratch based on the same idea. There's no direct crosswalk that's going to be able to give you exactly what you want. You can do some from SNOMED to I'9 and a little bit to '10, but you can't go the other way. But to say "90%," I would say that's only 1 in 23 items. We have communication; we have (I'm just reading here) devices, diagnostic studies—problem is only one-twenty-third of the issue.

The other areas that—and you have a good comment about RxNorm. We have had folks tell us that RxNorm generally is good, but not everything maps to it, and the right component ought to be used so that there aren't drugs being left out, and that it would be nicer to have even a higher level of, say, for instance, [indiscernible] inhibitors. And that's what NDFRT does, but I'm not sure if that's ready yet for implementation. I know, clinically, most have not implemented that.

So the answer is, it isn't as straightforward as "Just go with the three."

Danny Rosenthal – INOVA Health System
And hi, Floyd. This is Danny Rosenthal. I think that Tom's comment and your response, Floyd, also highlight some of the flexibility for SNOMED. And I think maybe Tom was referring to—90% of the other QDM concepts or categories also have SNOMED CT as—

Tom Tsang – Office of the National Coordinator
Yeah, that's what I meant, Danny.

Danny Rosenthal – INOVA Health System
Oh, thanks. [Indicernible]

Floyd Eisenberg – National Quality Forum
Oh yeah, that's a good point. You're absolutely right: A lot have SNOMED. But you understand that that was not because some committee said to us that's what we should use; in HITSP, they had done that, and that is very helpful. But we want to make sure that there's agreement that that's still the go-forward way to make it work. I will also insist there's some areas in SNOMED that are modeled slightly differently, because they were modeled for a different purpose, and will take some work to figure out how to best use.

Marjorie Rallins – American Medical Association
Floyd, this is Marjorie. I do have a question about the encounter and the recommendation for SNOMED, and maybe this isn't where we need to get into a detailed discussion. But what I can tell you is, the IHTSDO, the group that develops SNOMED, tends not to include and will probably be removing content that has an administrative persona, connotation, whatever. So an encounter itself really fits with CPT, and if we're looking for encounters, I would suggest that we not recommend SNOMED. Although there is some limited encounter data there, I don't think that useful long term.

And my other comment is, in specifying or developing measures for EHRs, I think one of the reasons why we have the encounter data element is, that's just how we think about certain data elements, and maybe an encounter isn't an appropriate data element when you're looking for data in an EHR anyway. So that's two comments.

Floyd Eisenberg – National Quality Forum
Actually, I very much appreciate that comment. And so, part of the reason for actually even saying "SNOMED"—I understand your point—is, as you've said, we've been using "encounter" because that's how things have been based; but if we're—I guess this is really thinking a little broader to consider that there has been some interaction between a clinician and a patient or between two individuals that doesn't have to be a typical visit or encounter or telephone visit, but there is—so in some of the measures, we just have to say, "There is a hospital admission, and during that hospital admission, this has occurred." And any admission counts, so we either have to take all CT for the physician or all I'9 procedures for admission, or can we say generically "an admission," meaning the patient was admitted and discharged from the hospital? And in some of those cases, we used SNOMED for that reason, but not to indicate an administrative or billing issue.

Marjorie Rallins – American Medical Association
Right, and I understand that. It's just that Dave would consider that admini—even though our context of use isn't administrative in nature, that's how—Dave would take some convincing, and…

Floyd Eisenberg – National Quality Forum
Yeah, so I understand that we need to be able to state that concept.

Marjorie Rallins – American Medical Association
Right, and I think there's other ways—and we can have that discussion offline, and I'll tell a few about it—to sort of—how do we reflect a relationship or connection between a physician and a patient, for example, without having to look at, necessarily, encounter data? And we can talk about that later.

Floyd Eisenberg – National Quality Forum
That's actually the purpose for bringing it to the Committee: so that we can do that. But that's good.

Jim Walker – Geisinger Medical Education
This is Jim. I just agree with Marjorie that the encounter is fundamentally an administrative category, whether or not a billing category. It might be that there would be something like clinical activity or something that would be what we're trying to get at. We need to remember that we will be accounting for things like interactive psychotherapy, in which some provider or team provides the opportunity, but the actual activity is between a patient and a computer, period. And so, we're going to have to think a little more about—I think there is a category that, a real set of things or activities, but "encounter" doesn't do a very good job of capturing it. And probably neither SNOMED nor CT or '9 or '10 will be adequate going forward. I mean, we'll need to pick something and get started, but whatever it is is going to require fundamental rethinking.

Marjorie Rallins – American Medical Association
Yeah, I agree, and I don't think it's necessarily a terminology that gives us that information. I think there's other types of EHR structure and function that we might need to look at.

Floyd Eisenberg – National Quality Forum
And I'd also say, I do agree with this discussion. It's a matter—some of this is historical. But I wonder if some of what we're talking about is "An intervention has occurred." And in the QDM, we would indicate who or what or how that was provided. It's part of one of the attributes that's applied to the intervention.

Jim Walker – Geisinger Medical Education
Yeah, this is Jim. That's much more along the lines of what it probably needs to be.

Floyd Eisenberg – National Quality Forum
So we may well not, in the future, end up using some of these QDM categories, because they're more historical, like "encounter."

Jim Walker – Geisinger Medical Education
Well, I think there is a bucket here. I just don't think "encounter" is the right construct for it. There is this set of, like you say, interventions; it's a record of a set of care activities arranged for a patient, which often involve a provider—sometimes don't. "Encounter" probably isn't the right construct, and none of those vocabulary code sets are going to get us very far down the road.

Marjorie Rallins – American Medical Association
Jim, this is Marjorie. I agree: It isn't the right construct. But when we're developing a measure from the beginning, that's how we think about it. And I think we need to think about how measures will be developed for EHRs with the EHR in mind as the data source at the onset of the development of the measure, because those that actually create the measure specifications take their guidance from the measure language, which mentions an encounter [indiscernible] construct that we need to look at.

Floyd Eisenberg – National Quality Forum
And I actually like this conversation a lot. If you look at the screen, I think what's described here as an intervention can deal with a lot of what you were just talking about. And so, we may just not need the other category [indiscernible] have a category that I think we do that you're looking for.

Jim Walker – Geisinger Medical Education
This is Jim. You may well be right, Floyd.

Floyd Eisenberg – National Quality Forum
I mean, I'm not saying it has to be right, but—

Jim Walker – Geisinger Medical Education
No, what it would mean is that we'd have the construct and intervention, and then we'd just have to know things like who provided it, who monitored it—the sorts of things that are components of what we now call encounters.

Floyd Eisenberg – National Quality Forum
But then we would need a code set to describe the intervention.

Neil Calman – Institute for Family Health
This is Neil. I also just got a comment and my opinion [indiscernible]. I think there's two parts of discussion. One is Marjorie's point that I think is—well, I certainly take it very well, which is the direction of SNOMED CT with respect to administrative elements. And then the second is the encounter versus intervention issue in terms of quality measurement in general. And on the second point, I think it's still worthwhile to retain but also make a distinction between what the process of care is doing and what is happening to the patient. And in the future value-based purchasing, value-for-health care model, we won't be getting rid of closing measures that seek to relate the value in the process of care and outcomes that are cheap. So it will be important to retain things that actually do have administrative elements, although they're less pure with respect to what happens to patients. So I think both encounters and interventions should remain as concepts in my opinion, and I'm not sure if encounters will be completely [indiscernible]. But I think the original point Marjorie made is still on the table, which is, "Is SNOMED CT really the correct standard against which to model encounters if, in fact, the SNOMED issue is moving away from administrative data?"

Marjorie Rallins – American Medical Association
Yeah. I mean, I know firsthand, because I have actually submitted for new content, and that particular type of content was not accepted for that reason. But I agree with your earlier comment that there probably needs to be some retention of the concept of encounter. However, I strongly believe that as measure developers, you really need to understand: "Do you think about an encounter? Is it really an encounter that you want to use as a data element when you are really interested in an intervention?" I just wanted to make that point.

Floyd Eisenberg – National Quality Forum
And it sounds like we're all generally in agreement. I guess my question is, looking at the time and the agenda for Tom, Jim, and Karen, we could certainly go through each of these 23 elements and have a discussion, but I think timewise—the question really is now, "This has all been terrific. How do we move from 'Here's the definition; here's what we're looking for,' determining what code set to work from?"

Karen Kmetik – American Medical Association

Thanks, Floyd. This is Karen. I think perhaps it is a good time, then, to move toward the presentation of the workplan to actually accomplish getting this done, with your laying out the framework so nicely. Jim, do you agree?

Jim Walker – Geisinger Medical Education
Yeah, although—maybe it's part of the workplan, but Floyd, I think at some point it'd be useful to identify which of the concepts there's pretty general consensus on what the appropriate code set would be and which ones need further work.

Floyd Eisenberg – National Quality Forum
Well, so in that regard, I guess where thought there was generally good consensus, after comments that have come in after the retooling, I'm not sure there actually is. So for, say, "problem," it was often "What problem, condition, or diagnosis?" I won't spoil in front of you, because I will give people headaches. But I thought it was SNOMED, but I'm not sure that's true anymore as we look for the future. And is there interim duality and a preferred-for-the-long-term feature? And so, I would say meds, I thought, was pretty clear as RxNorm, but there's been pushback on that. And aside from those, I'm not even sure there's full agreement on physical exam vital signs, where someone says "SNOMED," someone says "LOINC," and there's Clinical LOINC. So I hate to put out there that I think they're all up for discussion, but from everything I've been hearing, I think in some ways they are.

Jim Walker – Geisinger Medical Education
Well, this is Jim. Back to Karen's point, is that part of the workplan proposal that we're going to be hearing, or is this question separate?

Floyd Eisenberg – National Quality Forum
I believe it's part of the workplan.

Jim Walker – Geisinger Medical Education
OK, then I'd agree with Karen: Let's go ahead and move on to the workplan.

Karen Kmetik – American Medical Association
We have some folks from Accenture here to walk us through that. And Mara, were you going to introduce them? [Pause]

Tom Tsang – Office of the National Coordinator
This is Tom. Are the Accenture folks on?

Amy Berk – Accenture
This is Amy; I'm here—Amy Berk.

Tom Tsang – Office of the National Coordinator
And Heather?

Amy Berk – Accenture
I'm not sure. I'd be happy to walk through the conference slides.

Tom Tsang – Office of the National Coordinator

OK. So I just want to give folks a little bit of background on the next steps, and perhaps, Jim and Karen, I guess, with your endorsement, then we can move forward. So as you can see, there's a lot of work going on within the [indiscernible] process of the Vocabulary Task Force as well as the vocabulary harmonization process ONC has recently engaged Accenture to start off with. They've been working on two pilots in the S&I Framework: a care coordination pilot and a labs coordination pilot as well. And we thought we could have them help us move this process along by engaging them in the behind-the-scenes work of perhaps working with the—so they already have—working through the SDOs and the Vocabulary Task Force that they could start off with making a series of recommendations and connections and then coming back to us. But Amy, can you take over?

Amy Berk – Accenture
Sure, thank you. First of all, let me just say Heather is on the line, but she's not in talking mode, so she has been here the whole time. And in regards to the process, there's a time frame between June 6, today, and June 22. So today we're going to present our approach to this workgroup; and the week of June 6 through the 10th, this coming week, we will confirm the format for identifying and supporting necessary recommendations. We will then draft these recommendations and provide to the Clinical Quality Workgroup for your review and then relevant SDOs for their review as well. Then beginning on June 13 and that week, June 13 through the 17th, we will address the feedback and provide updated recommendations for review once again. By June 20, we would then finalize the recommendations with this workgroup once again and then present the recommendations to HITSP on June 22. With this in mind, the goal being that we want to optimize the standards in the context of the S&I Framework, hence the initiative that Tom just mentioned, TFC & LRI; eliminate any ambiguities for EHRs going forward—and then context and use of data elements will largely serve as the basis for recommendations. And some of these data elements may need to be stratified across multiple code sets, as was just exemplified by the conversation that Floyd and Marjorie and others had had. So are there any questions on what I just said?

Floyd Eisenberg – National Quality Forum
This is Floyd, and my first question is, I think that trying to address all these in that short time frame—I know I've been in other meetings where, whenever something is to be addressed, there are competing code set sponsors that all want to have their considerations heard. Will that be happening?

Amy Berk – Accenture
Right, so that's where we would present to those other SDOs and get their feedback and review of our approach and intertwine them within the process.

Tom Tsang – Office of the National Coordinator
I think, Floyd, that June 22 is something that we're trying to aim for, and apparently we want to engage the Clinical Quality Workgroup members here on this call in the process, and we want everyone's input. And should we get delayed, I think we'll just have to deal with that as time approaches.

Rosemary Kennedy – National Quality Forum
This is Rosemary. Just a question: So draft recommendations will be developed and then vetted through the SDOs as well as this Committee? Am I summarizing accurately?

Tom Tsang – Office of the National Coordinator
That's correct, and also we'll try and get input from the Vocabulary Task Force as well.

Rosemary Kennedy – National Quality Forum
And is there a certain aspect of this that may be related to the actual implementation of it, the operational use? And how will we get that feedback? Or maybe we've received that feedback already.

Amy Berk – Accenture
In regards to operational use, as in regards to the use cases themselves, Rosemary? I'm sorry.

Rosemary Kennedy – National Quality Forum
Yeah, I'm thinking of the use cases and the actual opportunities and providers in terms of implementing it within the electronic health record. I think Floyd identified a few. And some probably we don't have answers for, but some—there may be recommendations or things to do to facilitate the integration within the EHRs at the point of care.

Amy Berk – Accenture
Right, so part of this process, then, is the work that we would do, hence myself and our team as my framework, to make those recommendations on those 23 data elements that have been defined as part of Transition of Care Initiative and others. And we would then incorporate that work back into the overall process of the S&I Framework. Hence, right now, we're in the harmonization phase of activities and look at the outputs of these recommendations and hopefully harmonize them back into what harmonization is doing in their activities [indiscernible].

Tom Tsang – Office of the National Coordinator
And I think we're still going to have these conversations, Rosemary, in this venue here so that we can actually—that all of you will get the opportunity to give input in that process.

Jim Walker – Geisinger Medical Education
This is Jim. One might imagine that the vocabulary workgroup had made recommendations for these 23 categories. Is that not the case?

Tom Tsang – Office of the National Coordinator
I don't think that's the case, Jim.

Floyd Eisenberg – National Quality Forum
It is not the case. They referred it back to this group.

Jim Walker – Geisinger Medical Education
What was the reason that they referred it back to this group?

Floyd Eisenberg – National Quality Forum
Doug Fridsma has suggested that I…

Jim Walker – Geisinger Medical Education
Did they refer it back with considerations and pros and cons or without any…

Tom Tsang – Office of the National Coordinator

They just thought your expertise here in this group was [laugh], I guess, more relevant than—this is the—I guess that, originally, when we reinvigorated this group, that was one of the, I think, original tasks and objectives of this group: to seek your expertise and your guidance in this matter.

Jim Walker – Geisinger Medical Education
I wonder, as part of the workplan, if we wouldn't get where we want to go faster if we had a joint meeting of the two groups so that we can put the expertise together. It seems to me that this workgroup is going to want to know what Betsy Humphreys and Clem McDonald and Jamie Ferguson and the other people on that workgroup and some joint members, Chris Chute and all, think that pros/cons/other considerations are and put that together with the clinical need. And it seems to me we could spend a lot of time playing telephone if we don't have a joint meeting.

Tom Tsang – Office of the National Coordinator
I think that's a great recommendation, and perhaps the Accenture Team could help out in doing so.

Jim Walker – Geisinger Medical Education
Jim again. Perhaps part of the agenda for that meeting would just be to bang through all 23 and at least surface the issues if not come to conclusion on some of them.

Tom Tsang – Office of the National Coordinator
Are you on, Judy?

Judy Sparrow – Office of the National Coordinator
Yeah, I am.

Tom Tsang – Office of the National Coordinator
Do you know whether they have a meeting coming up, a work meeting?

Judy Sparrow – Office of the National Coordinator
They do: They have one on June 24, Vocabulary Task Force; that's their next meeting. So we can talk offline about how we can—

Tom Tsang – Office of the National Coordinator
Yeah, how we can structure this, maybe via administrative work call, and just bang this out.

Judy Sparrow – Office of the National Coordinator
Right, OK.

Phil Renner – Kaiser Permanente
This is Phil Renner. I have a—

Floyd Eisenberg – National Quality Forum
[Indiscernible] the number 23, because some of these have components underneath them if you look at—

Jim Walker – Geisinger Medical Education
No. This is Jim. Sorry, Floyd. That was just a placeholder. Ignore my inaccuracy.

Floyd Eisenberg – National Quality Forum
No, it's not—it's just we've all been saying 23, except there's actually more than that now.

Jim Walker – Geisinger Medical Education
Yeah [laugh].

Tom Tsang – Office of the National Coordinator
Sorry, I think Phil had a comment.

Phil Renner – Kaiser Permanente
Yeah, this is Phil Renner. I had a question for the Accenture team. I think one of the concerns that arises around some of these code sets is the degree to which people have experienced actually using them. And I was wondering if part of your workplan was going beyond the SDOs and potentially advocates for some of these code sets to any health care organizations that are actually using these terminologies in their EHRs now, so either vendors or delivery systems that are doing this. Is that part of your workplan or questions that you're asking?

Amy Berk – Accenture
Well, the questions certainly are true, and we hadn't [indiscernible] thought through the vendor scenarios, speaking with them. But that's absolutely a good recommendation, and we can certainly consider that in the workplan itself.

Rosemary Kennedy – National Quality Forum
This is Rosemary, just to dovetail on that question: The providers as well that are working with them in addition to the vendors and the standards organizations—I think is really a phenomenal, great source of information that can help guide us.

Amy Berk – Accenture
Oh, absolutely. And as [indiscernible] I just mentioned, we can certainly take from the S&I community members, hence there are vendors within the S&I community that could provide the expertise. And I can see that was mentioned.

Phil Renner – Kaiser Permanente
Because we've got to really think about what's the bridge or transition strategy between the current billing code sets and these more clinically meaningful code sets.

Tom Tsang – Office of the National Coordinator
Amy, I think the point is also including the providers and organizations, besides the vendors.

Amy Berk – Accenture
Yes, absolutely. I was using vendors as an example, but yes: vendors, providers, and others that have an interest within the work that we're doing as part of the S&I community again.

Tom Tsang – Office of the National Coordinator
Yeah, I think those are great recommendations.

So, Jim and Karen, I think we have a good plan to move forward. So I don't know if you guys want to wrap up, and we can go over some of the action items or next steps.

Karen Kmetik – American Medical Association
Karen. I think we've got a good plan to go forward. I concur with the idea of combining with the vocabulary group. I think it'll just make things more streamlined. And I just want to emphasize, because I think we heard some of this at the testimonies to both our group and the other quality workgroup that David Lansky leads: It's one thing to say this is the code set that we're going to use; it's another for it to be the actual code set that's being used in an EHR and provider site. Plus, we heard about concerns about versioning of those code sets. And that's probably beyond the scope of this. And I think, once we get to the right or at least the recommended code set that we will recommend [indiscernible] concept, I guess that will start to send the message. But somewhere just within our parking lot, I think, is a discussion about—and perhaps that's what the EHR vendors and providers—"How do we get to a place where we're comfortable that whatever code set is selected here for QDM, and therefore measure developers are using it to define the measure elements within that QDM concept—we're all on the same version of that code set that's being used out in the field?" I'll just leave that there.

Jim Walker – Geisinger Medical Education
And when you say "version," you mean, for example, ICD-9 versus ICD-10.

Karen Kmetik – American Medical Association
Right, or we heard some testimony that it's in the hands of the providers sometimes to download the update to RxNorm. Or in this case, they were talking about NBC.

Floyd Eisenberg – National Quality Forum
So Karen, I think, to follow on that, the RxNorm that updates every 2 months and other things—6 months or a year—and how do you keep up to date? And I think to align with that, we also want to consider, again, the concept of a value set registry so that things can be kept up to date with vocabulary experts, at least for consideration, because that's been one of the challenges: Once they're developed, keeping them up to date is a huge task.

Karen Kmetik – American Medical Association
Right, OK. All right, so what I'm hearing is that, Judy, you were going to explore combining with the already scheduled vocabulary group, but then we're looking for the Accenture Team to really drive these next several steps. Is that right?

Judy Sparrow – Office of the National Coordinator
Yeah, I will work on making the date happen. And I guess I'll talk to Accenture and Tom about the other.

Tom Tsang – Office of the National Coordinator
I'm wondering, Jim and Karen, if it would be helpful for folks to just take a look at that Excel spreadsheet that Floyd sent and perhaps mark it up. And if you have any preliminary comments, it would help us to expedite the process, if you want to send any comments to us through email.

Jim Walker – Geisinger Medical Education

This is Jim, Tom. We have 20 minutes till public comment is scheduled for discussion. Do we have anything else we need to discuss besides starting some discussion that you just mentioned?

Tom Tsang – Office of the National Coordinator
I think we covered everything on the agenda.

Jim Walker – Geisinger Medical Education
Then I would just make a couple of points about the word table that Floyd sent out. I think one is that, at least in clinical usage, "contraindication" is a superset of "allergy" and "intolerance," and clinicians almost never use the word "intolerance" also. So I think that's something to think about, Floyd, particularly because that's, at least in the squares there, overlap. So I think that might make the idiom structure a little more clinically intelligible and a little simpler. Obviously, we'd need to keep the two things distinct at a subset level.

Second thought is more or less trivial, but I think if we called it "non-lab diagnostic studies," rather than expecting people to know that diagnostic studies didn't include labs, we would again conform to general, very widely distributed clinical logic and people could read the table with a little more ease and understanding.

Third, similar thing: "Functional status" doesn't really distinguish between general measures (as SF12 and 36 and so forth) and disease-specific measures. And I would think, as we're working through this, that's going to be an important distinction: "What is the appropriate disease-specific measure for arthritis or whatever it is?" as well as "What are appropriate measures for different kinds of settings, perhaps?"

Another one is the distinction between "intervention" and "procedures." It's logically tortured—doesn't make sense in natural English or clinical English. And we probably want to look at making that clearer for perhaps recognizing it as a spectrum that runs from "very noninvasive" to "highly invasive" rather than two distinct buckets that make any particular sense as distinct buckets.

Another similar thing: the distinction between "adverse effect," "adverse event," and then distinguishing "adverse effects" from "medication allergy" and "intolerance." That's all extremely unclear; again, it doesn't match the way clinicians think or talk and probably introduces unnecessary complexity. It might be that "adverse effect" or "event," one or the other, is a superset under which contraindications and other things fit.

So that's the set I have, just thinking about the logic of this and trying to make it a little cleaner and a little more representative of the way clinicians think. And I don't think the way it's presented is particularly representative of the way patients would think, so I'm not sure that there would be any loss from rationalizing it a little bit.

Floyd Eisenberg – National Quality Forum
OK, I appreciate all those comments. And in general, we did, in trying to describe this—and now it's been our fourth set of comments related to some of these things. "Contraindication" certainly makes sense. There are, in measures at least and even clinically, folks who want to separate what is true allergy versus what is because of some other adverse thing that happened—that the patient won't tolerate or won't take it. And we end up in semantic discussion.

Jim Walker – Geisinger Medical Education
Floyd, this is Jim. I agree with keeping the two subdivisions. It's just that if there was a superset of contraindication, it would just make those two buckets—#1, they'd be 13A and 'B or something rather than being 8 or 10 separate.

Floyd Eisenberg – National Quality Forum
No, I don't mind that. I think the problem is, there are those who would say there are diagnostic contraindications as well, which is the only reason we didn't do that, because there are also contraindications related to certain patient characteristics. You could have a measure that says "not if they are above a certain age," and some are listed as exclusions for that reason. So it's just a matter of how you define the term. But that's fine as far as "lab" versus "non-lab"; it's just another word.

"Intervention" and "procedure" has really gone back and forth a number of times. And in some ways, "procedure" has been often used to indicate something that happened and is still, and "intervention" is not, but we did not want to say, "Some are billable; some aren't." And the way "intervention" currently is listed is, it's something a patient can do for him- or herself as well, so even though you might do it as a physician, the patient can still treat with that. And it is a spectrum, but not having something else to indicate that patients delivered self-care—got lost in the term "procedure." So admittedly, there has to be a different way to say it; the actual pattern in the XML is the same thing. So it's a matter of "How can we describe that?" And we've been challenged, because responding to the comments hasn't really given us a good way to describe that. We have some who insist we have "intervention" separately.

So we're looking for some advice. None of that really indicates what code set to use. But I understand having better definitions will help us.

Rosemary Kennedy – National Quality Forum
Jim and Floyd, this is Rosemary. There's probably two levels of feedback here, and are you looking for feedback on the QDM concepts as well as the code sets? I realize there's probably some interrelationships. But the QDM, I guess, is extensible, so as it changes, hopefully it won't impact the code sets.

Floyd Eisenberg – National Quality Forum
Yeah, so Rosemary, I think what I'm hearing is comments on the QDM definitions. And I think they're good comments, and they can be modified somewhat. But as far as the code sets, I don't know if that would change anything, because what I—so say we took "contraindication" as a parent to "intolerance" and "allergy." I still have the issue of "How do I say if it's related to a med? How do I say it is an adverse event versus an adverse effect versus intolerance?" And if you'll notice in the new definitions, this year we only have "intolerance" as one thing; it's rolled up. So it's just a matter of "How do I say that in what code set?"

So "non-lab" versus "lab": I think a different term for that in the QDM is not a problem as long as you look at the definition for the folks determining on the code set. And "intervention" or "procedure" may not matter a whole lot either. So I think you're right: What I'm hearing is comments on how the QDM is defined.

Rosemary Kennedy – National Quality Forum
Yeah. I know it was open for public comment, and you're probably processing the comments at this point of time, similar to what Jim is talking about, OK, because along that vein, there are clinical code sets, but there's also administrative and financial code sets as well, which I'm sure, in the public comment, you're hearing about.

Floyd Eisenberg – National Quality Forum
Right. Now, the other thing we also have to be cautious about: the fact that clinicians might want everything in an allergy list, whether it's a true allergy or it's not. Is it necessarily the right way to do it clinically? So I think some of this was to help derive some differentiation where it might need to happen, because—

Jim Walker – Geisinger Medical Education
Floyd, this is Jim. That's precisely the point. And it doesn't matter what we call it; if "contraindication" doesn't work, then call it "reasons not to give the patient a med." The point is that in the thought process, what a clinician—physician, usually, although others—is thinking is, "This patient should have an ACE inhibitor for their heart failure. Is there any reason not to do it?" And if their potassium goes to lethal levels when they're given an ACE inhibitor, that needs to be in the same place as "type I reaction." And that is precisely the point: that for safety and efficiency and quality, the two have to come to the same location in the EHR, even though it makes perfect sense to say, "They're two separate things, and we're going to have two different registers and perhaps even two different code sets." But part of the point is that if the logic of the QDM doesn't map, where it's reasonable, to clinical logic, it will mean that quality teams that are developing recommendations, who are prone to be clinicians and think clinically, will be trying to translate their thought into something else, and we'll end up with the kinds of mistranslations between clinical guideline intent and the ability to execute them in EHRs that we've got now.

Floyd Eisenberg – National Quality Forum
No, that's actually very good feedback. And actually, even though they're separated because of that sabbatical, the XML patterns that deal with the interoperability are nearly identical, except one's saying "intolerance" and one's saying "allergy." But they're intended both as, in a sense, contraindications—reason why not. So it's a matter of, at the top end, the readable one, putting them together. So I take that as very good feedback, and we'll certainly look at that. I'm not sure that the code set discussion needs to wait for that, though.

Jim Walker – Geisinger Medical Education
No, I agree. But I just think if we get the structure as rational as possible, it will help things down the road. It almost always does.

Floyd Eisenberg – National Quality Forum
Right. I will say that the idea of "intervention" versus "procedure" does have an impact if we would pull them all together. For instance, "A doctor's performing a procedure" very easily could be a CPT code if they're billing for it; but if it's a non-billed thing, then I have to be able to say it. And if the patient does it for himself or herself, I have to. And they wouldn't—unless you're using CPT for other purposes than billing, which you could (you might need more codes), how would we do that? So that's the advice we're looking for.

Jim Walker – Geisinger Medical Education
Well, see, this is Jim. So clearly, removing the skin tags is a procedure, or at least it's usually called that, and it's in CPT. Patients can do that themselves. What I'm arguing is that it's a spectrum from things that rarely anybody but a patient would do, maybe after they were trained once, to things that nobody could do for themselves, like open-heart surgery. And there are a set of characteristics that together define where on a spectrum that thing is. But to act as if there's a wall somewhere between one end of the spectrum and the other end of the spectrum—my argument at least is that that would cause unending confusion and foolishness, because it just isn't a wall. I mean, we're having patients manage their own warfarin dosing now that—I don't know if that would have ever been called a procedure, but something that patients didn't do for themselves that they do now. It's like the move from operating room to outpatient surgery to clinic and maybe farther. If we define these thing epiphenomenally by things that are not fundamental to them, when those things change, then we'll have a bunch of categories where it's obvious they don't make any sense.

Floyd Eisenberg – National Quality Forum
No, and again, I'm not disagreeing at all. We've gone back and forth on this whole issue. The concern I would have on the code set, though, is how do you describe "Walk in hall 15 feet on day 2 after surgery" and then exercise this to a certain capability, which often a patient can do for himself, or wound care, which again they can do for themselves—that, yes, they have some training. But what I'm looking for is "Are we dealing with the same code set to describe all of that from the spectrum of the patient doing it all themselves all the way to the open-heart surgery?" And by pulling it together in the QDM definition, that's another argument to go back to one thing instead of two. I have no problem with it. It's just a matter of "Does it still use the same code set, or when and where and how do we split?"

Marjorie Rallins – American Medical Association
Floyd, this is Marjorie. I just wanted to make a comment that the procedure/intervention discussion has been discussed at length in the IHTSDO world, and SNOMED considers a procedure to be anything from seeing a patient in an office to doing an open-heart surgery. So these three examples that you gave could all be represented in SNOMED.

Floyd Eisenberg – National Quality Forum
And so, if the answer were, "It's all SNOMED," that's fine. That's what we're looking for. But if the answer is not all, then I want to know how to make the differentiation.

Marjorie Rallins – American Medical Association
OK, so do you want that—you don't want that now; I mean, I have some thoughts on that.

Floyd Eisenberg – National Quality Forum
I guess that's up to the chairs if they want.

Marjorie Rallins – American Medical Association
Yeah, I'd like to write my comments and send those in.

Jim Walker – Geisinger Medical Education
That would be fine. We do have 10 more minutes before the time for public comment.

Rosemary Kennedy – National Quality Forum
Jim, who do we send your comments to? Because I just have some related to functional status and some other code sets that are needed as we move forward. Do we send them to you, or do we send them to Amy?

Jim Walker – Geisinger Medical Education
Judy, who would that be?

Judy Sparrow – Office of the National Coordinator
You can send it to me, and I'll make sure it gets distributed to the right people—to everybody, that is.

Rosemary Kennedy – National Quality Forum
Oh, Judy, that's you, right? OK, thank you very much.

Jim Walker – Geisinger Medical Education
Judy's like a nurse: She's the universal solution.

Floyd Eisenberg – National Quality Forum
She's a triage nurse.

Rosemary Kennedy – National Quality Forum
Holding it all together [laugh].

Floyd Eisenberg – National Quality Forum
Yeah, I do think that—I mean, I've had folks talk to me about "What about Clinical LOINC versus SNOMED?", whether that ICF or functionality. And all those things are great to discuss. It's just that without a consensus, agreement, or some public vetting, NQF wouldn't go about just making an arbitrary decision, which is why we're approaching the Standards Committee here.

Neil Calman – Institute for Family Health
This is Neil. I have a related general query: So what is the purpose of the QDM? I think it's obviously, clearly helpful to quality informatics or quality [indiscernible] have the immediate specification language of the QDM to communicate and to help model and design quality measures. But is it the intent of the QDM, and the purpose of it, to standardize exactly at that intermediate level and not allow individual measure developers (like, for instance, comparing to public health surveillance) side more directly with code sets they would want to be measuring different [indiscernible] with or multiple code sets? In other words, do you think of QDM as a language that you compile into a lower-level language? Is there an intent to [indiscernible] development taking place at that lower-level language? Because, I mean, obviously, if I were asking a question in quality and had a particular purpose for my measure and I wanted to inform that process by an understanding of what people are using, what the physical reliability is of choosing SNOMED versus an older modeling construct or standard, and I wanted to reach a certain thing in a provider, etc., I might be very strongly influenced to take a particularly code set and just describe a measure at that low level. So if you can just give [indiscernible]…

Floyd Eisenberg – National Quality Forum

Sure. So I think the concept—and this is actually what we're looking for—of QDM is to be able to say what you want to say and do it. And actually, we're seeing adoption of that same model used in developing clinical decision support. So clearly, if you want to implement it today in an existing EHR and it has that capability, rather than have the EHR have to additionally approach greater reference terminology to do all the mapping, you would want something they use today.

One of the challenges, though, is, if we're trying to move to a more standard future with semantic interoperability, that it would be nice if we could align on the same way you should interoperate between two systems. You use the same terminology when you're evaluating quality. So one of the issues would be, to pick RxNorm as an example, when I say, "Just give it to me in FDB, because I know FDB; that's what I use; I don't have to map," and somebody else will say, "Wait a minute; I use Multim." So a quality measure developer would have real problems trying to create one for everybody's implementation and deal with that, or each vendor would have trouble trying to map from one to what they currently have.

So that's why a more central terminology, which is taken from the certification rules and the meaningful use rules, was the RxNorm. To say that a measure developer can choose whichever they want—that's OK, but I would think if some measure developer decided, for instance, right now they liked ICF to talk about functionality and no one's implemented it and everyone else is using something out of—I'm not sure what—then that would really make it difficult. If, on the other hand, all current measure developers stay with what they use today, then how would we move the EHRs forward? So I don't know the best answer to that. To say you could use either—and perhaps the Standards Committee should, in interim, provide two options, so give ICD-9 and SNOMED or '10 and SNOMED, but with clear direction that, by a certain date, they want it all to be the idealized one. I think that's reasonable. I just don't know—I can't make that decision for you.

Tom Tsang – Office of the National Coordinator
Jim, can I attempt to answer that comment?

Jim Walker – Geisinger Medical Education
Please.

Tom Tsang – Office of the National Coordinator
So Neil, this is Tom from ONC. I think in discussions of CMS and multiple other agencies, I think we decided to adopt the QDM as a data model as a building block to really think about standardization of quality measures and having really, I guess—and starting a process of engaging both the measure developers as well as the public community and vendors and everyone else involved in measure development in general is really about coming out with a standardized data dictionary to express these things so that there's very few ambiguities. And the implementation challenge that we've been hearing is that it's all about having too many variations in the code sets and how to express the logic models. That said, I think the QDM model is elastic enough that, as the need arises in terms of expressing either clinical processes or patient processes where there's no data element there, there's an opportunity to actually work with NQF and create a new set of data elements to express those new concepts. So some of the things that I think NQF has been given direction to—in terms of developing new data elements are some of the behavioral health measures and some of the patient-reported outcome measures and even measures that may look at resource use and utilization and health economics.

So certainly, I think your concern about public health measures is a valid one. And if we aren't meeting your needs, you can certainly give comments to NQF on this model. And this is exactly what the conversation should be.

Neil Calman – Institute for Family Health
Well, I mean, I guess this'll be only one more comment before I take up the time. But Floyd, part of when we're developing our clinical effectual list repository of longitudinal data surveillance tools, the question of looking backward and then looking forward always comes up. And so far, as you can probably tell, [indiscernible] 100 years' worth of trend data on ICD-9 codes from death certificates. And you say, "Well, we want to incense clinical physicians to use SNOMED, because the semantics are better, and you can—for future exchange transactions" [indiscernible] gets better for everybody [indiscernible]. But what do you do when you're doing a 30-year-long trends analysis? You have to have [indiscernible], looking at old data sources.

So you can't just make a futuristic kind of argument; you have to look at semantic use, so over time. And so, it's not as simple as just picking the best. I think it's really a question of interoperability, both currently between entities and back and forth to [indiscernible].

Floyd Eisenberg – National Quality Forum
This is Floyd. I think I have just heard a good argument in discussing what—that code set should be used. There should probably be not just "What is the best for the future? What's the near term?" but also, to do that kind of retrospective analysis, what makes sense, because that's where the data are. So I like that concept.

Neil Calman – Institute for Family Health
Well, I guess this is a specific way that it would have any implications of any [indiscernible] authoring tool, instead of being philosophical and practical [indiscernible] authoring tool and allow the authors to drill down one level and then, in addition to the SNOMED list, also provide ICD-9 list/ICD-10 list and then just [indiscernible] only allow them to model at the level of the QDM, and then the standards and operabilities of standards [indiscernible] compile it after the right set.

Floyd Eisenberg – National Quality Forum
Well, actually, for the authoring tool—it's based on the QDM, but the allowable code sets that you can use—we want it to be able to limit so that you wouldn't come up with some code set that no one's ever used before and just develop your own—but limit it to the reasonable ones that you would use. And if it means that, because of look-back, you need to be able to include a parent value set that includes children on an I'9 and an I'10 and a SNOMED. And if you want to go back to whatever is before I'9—and that's important. We just want to know what options we should put in there so that we maintain some consistency and someone doesn't go in and put some code set that hasn't been evaluated or hasn't been used. We're just looking for that guidance. So if it means we need to have more in there, that's no problem; but if we list everything under the sun, then we may get some things that aren't practical. And that's why we're looking for what we—we also want to have recommendations. And we're looking for—

Neil Calman – Institute for Family Health
We need a legacy list and this time-based, time-balanced future adoption list. And that way, people could violate it by a couple years for some penalty, but basically we can have two different—one is

allowed to model, which includes a legacy plus the future, and the other is a future as an official incentive.

Floyd Eisenberg – National Quality Forum
I mean, that makes sense, and that's what we're looking for the tool. What I would also say is just for those who don't know a lot about the authoring tool, because it's not generally available yet: It's going to let you use any number of the allowable code sets, but it does not have a full repository of everyone else's value sets from which you can choose. Just the ability to create and version a value set is external to the tool. You can bring it into the tool and refuse it, but it's not a value set registry.

Jim Walker – Geisinger Medical Education
So this is Jim Walker. I think this has been a useful discussion. It sounds to me like we have a workplan identified to go forward from this meeting, so I think it's probably appropriate at this point to turn it to public comment, Judy.

Judy Sparrow – Office of the National Coordinator
OK, thank you. Operator, can you check and see if anybody wishes to make a comment?

Operator
Yes. If you'd like to make a public comment, please dial 1-877-705-2976 and press *1 to be placed into the queue. If you're currently on your computer, please press *1 to be placed in the queue. [Pause] And we do have public comments.

Judy Sparrow – Office of the National Coordinator
Hey, can you please identify yourself? [Pause] Ms. Bickford, your line is live.

Carol Bickford – American Nurses Association
Carol Bickford, American Nurses Association. On the table that was distributed, could you identify what code set was populating the cell for laboratory test #14?

Jim Walker – Geisinger Medical Education
This is Jim Walker. That one looks blank to me.

Floyd Eisenberg – National Quality Forum
It does, and it should have been LOINC.

Jim Walker – Geisinger Medical Education
Thank you very much, Carol.

Judy Sparrow – Office of the National Coordinator
Thank you, Carol. Do we have any other comments?

Operator
There are no other comments.

Judy Sparrow – Office of the National Coordinator
OK, back to Jim and Karen for anything closing.

Jim Walker – Geisinger Medical Education
Karen?

Karen Kmetik – American Medical Association
No, I think we know where we need to get. I would just echo that if folks want to send in written comments—to send them in while we schedule the next conversations to land on recommendations for the code sets for each of the QDM as well as comments on the QDM definition.

Jim Walker – Geisinger Medical Education
OK. Thanks for a very productive meeting. [Various signoffs]